Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Hospital and Non-emergency, Outpatient MRI/CAT/PET Scans providers participating in the Virginia Medical Assistance Program, Managed Care Organizations providing services to Virginia Medicaid recipients, and all holders of the Hospital, Physician, and Independent Laboratory Medicaid provider manuals

UPDATE: HM-PA-06

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

DATE: 05/26/2006

SUBJECT: Update to the *Hospital* Provider Manuals and New Prior Authorization Contractor: Effective June 12, 2006

The purpose of this memorandum is to provide information regarding changes to the preauthorization (PA) process for Hospital services and non-emergent MRI, CAT, and PET Scans, and to provide an explanation of the resulting updates to the Hospital Medicaid Provider Manual. Effective Monday, June 12, 2006**,** KePRO, DMAS' new PA Contractor, will accept PA requests for inpatient acute, and non-emergent outpatient scans for Fee-For-Service recipients. These changes in the prior authorization process do not apply to drugs on the Preferred Drug List (PDL), Medicaid contracted managed care organizations, dental services, transportation, MR & Day Support Waivers. These services will continue through the current vendors. Additionally, the DMAS Medical Support Division will continue to handle prior authorization for the following procedures: organ transplants, gastric bypass, cosmetic procedures, and prostheses (excluding orthotics).

KePRO IS THE NEW DMAS PA CONTRACTOR

As indicated in the March, 20, 2006 Medicaid Memorandum, DMAS has contracted with KePRO, an innovative healthcare management solution company, to conduct PA for Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus clients in the fee-for-service programs. KePRO was awarded the PA contract through the competitive bidding process based upon their ability to implement interactive web-based technology (iExchange) and to move the PA submission process from a primarily fax and paper-based process to a speedier, provider-friendly paperless process that the Department believes will reduce providers' administrative burden. KePRO will also maintain a process for providers who prefer to use a traditional paper based system, *i.e.* fax, mail, or telephone. As a result of the new contract, DMAS will be implementing changes to its PA procedures.

TRANSITION CHANGES / CLARIFICATIONS

The following provides important information regarding changes that will take place with the transition of prior authorization to KePRO:

1) KePRO will accept requests for prior authorization via iExchange (direct data entry through the web), fax, mail, or phone. The preferred method of submission for requesting PA is through iExchange. To submit requests via iExchange, log on to DMAS.KePRO.org and register for a provider web account. You must have a provider web account before submitting information through iExchange. To register for a web account, you must know your Medicaid provider number and tax identification number. Passwords will be issued weekly. If you choose to phone or fax your request to KePRO, your response will come back in the form of a fax. Instructions regarding how to customize the provider's web account to include drop down boxes specific to a provider's practice and services are available at: http://dmas.kepro.org/documents/iexchange/3%20iEXCHANGE%20Admin%20Training.pdf

2) In relation to inpatient reviews, concurrent review requirements are not changing from the current review process. Acute Med/Surg, which are paid on a DRG basis, will not require concurrent review. Inpatient psychiatric, inpatient rehabilitation, and comprehensive outpatient rehab facility (CORF) stays which are based on a per-diem payment methodology will continue to require concurrent review.

3) In terms of submission timeframes for acute inpatient admissions, providers will continue to have 24 hours (i.e., next business day) in which to obtain a prior authorization for all admissions. This includes planned admissions. Additionally, as with the current process under WVMI, providers may submit retro-authorizations to KePRO when notified of a patient's retroactive eligibility for Virginia Medicaid coverage. *DMAS will relax the requirement of timely submission for those requests received at KePRO through July 31, 2006. Starting August 1, 2006, timely submission for requests will again be applied and determinations will be made based on timeliness.*

4) Turn-around times are changing. The majority of providers will see decreased processing times. For inpatient hospitalizations, there will be a longer turn-around time compared to those who waited on the phone with WVMI for a PA number. This is because the clinical review will occur at KePRO and the eligibility edits will be applied through an overnight batch process. Providers are encouraged to verify eligibility and enrollment prior to submission to KePRO. This is because over 50% of recipients are enrolled in a DMAS Managed Care Organization. KePRO is handling the prior authorization only for the DMAS fee-for-service population. If the case meets clinical criteria, the case is pended within a few hours of receipt with a status of "meets clinical criteria awaiting final DMAS edits." Ninety percent of the cases will be approved if they meet criteria. As a result, hospital PA staff can look at the website the next day to obtain the PA number.

5) Frequently asked questions (FAQs) are posted to the DMAS and KePRO websites with responses. Please take a minute to review these to help you better understand some of the issues surrounding this transition and continue to check back, as these are updated regularly.

CHANGES RELATED TO PRIOR AUTHORIZATION PROCESS

WVMI will continue to process prior authorization requests for all Hospital services and non-emergency, outpatient MRI/CAT/PET scans with a date of receipt up to and including, June 11, 2006. Effective on and after Monday, June 12, 2006**,** KePRO will accept PA requests for these services. Additionally, KePRO will use InterQual criteria, a McKesson Health Solutions, LLC product when making medical necessity determinations at the non-physician review level. Supplemental criteria will be used where InterQual does not specifically meet DMAS' coverage criteria. Refer to the new Preauthorization Appendix of the Hospital Provider Manual for specific information regarding prior authorization submission procedures. To better serve you, KePRO will be operating with expanded hours of operation, from 8:00 a.m. to 7:00 p.m., Monday through Friday, EST (except on some state holidays).

Medicaid Memos regarding prior authorization are posted on www.dmas.virginia.gov under "what's new" and under "prior authorization."

KePRO will provide WebEx training to hospitals at a later date. Post cards will be sent to hospitals announcing date and time

KePRO CONTACT INFORMATION

KePRO will accept requests for PA via iExchange (direct data entry through the web), fax, mail, or phone. The preferred method of submission for requesting PA is through iExchange.

To submit requests via iExchange, log on to DMAS.KePRO.org and register for a provider web account. You must have a provider web account before submitting information through iExchange. To register for a web account, you must know your Medicaid provider number and tax identification number.

Submit requests on and after June 12, 2006 via phone, fax, or mail to:

KePRO

Toll Free Phone: 1-888-VAPAUTH (1-888-827-2884)

Fax: 1-877-OKBYFAX (1-877-652-9329)

2810 N. Parham Road, Suite 305

Richmond, VA 23294

PA REQUEST FORM

Attached to this memorandum are the Inpatient and Outpatient Prior Authorization Request forms for paper and fax PA submissions. These forms and accompanying instructions identify critical information to process all types of PA requests (i.e., whether received by web, fax, phone, or paper).

CHANGES TO HOSPITAL PROVIDER MANUAL

The attached tables show the changes to the manual. Please download and insert the new pages into your manual and retain the attached table. The changes described in this Memorandum are effective **June 12, 2006**. The most notable changes include: (1) revisions to Chapter IV and (2) a Preauthorization Appendix has been added.

UTILIZATION REVIEW AND CONTROL

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. Revisions to the prior authorization submission process do not relieve participating providers from program integrity standards as described in Chapters IV and VI of the Hospital Provider Manual.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

KePRO can be reached at 1-888-VAPAUTH (1-888-827-2884) to answer your questions regarding prior authorizations. Submit requests or questions via phone, fax, or mail to:

KePRO
Toll Free Phone: 1-888-VAPAUTH (1-888-827-2884)

Fax: 1-877-OKBYFAX (1-877-652-9329)

Mail: 2810 N. Parham Road, Suite 305
Richmond, VA 23294

Web via iEXCHANGE: http://dmas.kepro.org

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content

Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

HOSPITAL MANUAL
REVISION CHART
May 26, 2006

SUMMARY OF REVISIONS

MANUAL SECTION	MATERIAL REVISED	NEW PAGE NUMBER(S)	REVISED PAGE(S)	REVISION DATE
Chapter IV	Chapter IV (Covered Services)		Chapter IV (Covered Services)	06/12/2006
Chapter VI	Chapter VI (Utilization Review)		Chapter IV (Utilization Review)	06/12/2006
New Prior Authorization Information: Appendix D	New Appendix D		New Prior Authorization Information: Appendix D	06/12/2006
Table of Contents	Table of Contents		Table of Contents	06/12/2006

FILING INSTRUCTIONS

MANUAL SECTION	DISCARD	INSERT	OTHER INSTRUCTIONS
Chapter IV	Old Chapter IV (Covered Services)	New Chapter IV (Covered Services)	
Chapter VI	Old Chapter VI (Utilization Review)	New Chapter VI (Utilization Review)	
New Prior Authorization Information: Appendix D	N/A	New Prior Authorization Information: Appendix D	
Table of Contents	Old Table of Contents	New Table of Contents	

Outpatient Prior Authorization Request Form

DMAS/KePRO

Submit fax request for prior authorization to: 1-877–OKBYFAX (877-652-9329)
Requests may be submitted up to 30 days prior to scheduled procedures/services, provided Enrollee is eligible.

Recert: Enter previous PA#. Change or Cancel: enter PA# to be changed or canceled.

1. ❑ Initial ❑ Recertification ❑ Change ❑ Cancel PA #_____

2. Date of Request: (mm/dd/yyyy) ____/____/_____	**3. Review Type: (Please check one)** ☐ Retrospective Prepayment Review (Date notified of eligibility ____/____/_____) ☐ Retroactive MCO disenrollment			
4. Enrollee Medicaid ID Number (12 Digit number):	**5. Enrollee Last Name:**	**6. Enrollee First Name:**	**7. Date of Birth: (mm/dd/yyyy)** ____/____/_____	**8. Sex:** ☐ **Male** ☐ **Female**
9. Requesting/Service Provider Name and Medicaid ID Number/NPI:	**10. Treatment Setting:** ☐ **Outpatient** ☐ **Provider's Office** ☐ **Home** ☐ **Intensive Outpatient**	11. Primary Diagnosis Code/Description: (enter up to 5) **1.** _____ _____ **2.** _____ _____ **3.** _____ _____ **4.** _____ _____ **5.** _____ _____		
12. Referring Provider Name and Medicaid ID Number/NPI:		**13. PA Service Type:** ☐ **0050 Outpatient Psych** ☐ **0092 Orthotics (EPSDT)** ☐ **0100 DME** ☐ **0204 Outpatient Rehab** ☐ **0450 MRI** ☐ **0451 CAT** ☐ **0452 PET** ☐ **0500 Home Health**		
14. Severity of Illness (See instructions pertaining to each service type):				
15. Intensity of Services (See instructions pertaining to each service type):				
16. Additional Comments (See instructions pertaining to each service type):				

Outpatient Prior Authorization Request Form

DMAS/KePRO

Number	17. HCPCS/ CPT/ Revenue Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Actual Cost per Unit	22. Frequency	23. Total Dollar Requested	**24. Dates of Service**	
								From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.								___/___/_____	___/___/_____
2.								___/___/_____	___/___/_____
3.								___/___/_____	___/___/_____
4.								___/___/_____	___/___/_____
5.								___/___/_____	___/___/_____
6.								___/___/_____	___/___/_____
7.								___/___/_____	___/___/_____
8.								___/___/_____	___/___/_____
9.								___/___/_____	___/___/_____
10.								___/___/_____	___/___/_____
11.								___/___/_____	___/___/_____
12.								___/___/_____	___/___/_____
13.								___/___/_____	___/___/_____
14.								___/___/_____	___/___/_____
15.								___/___/_____	___/___/_____
16.								___/___/_____	___/___/_____
17.								___/___/_____	___/___/_____
18.								___/___/_____	___/___/_____

25. Contact Name: _____

26. Contact Telephone Number: _____

27. Contact Fax Number: _____

Outpatient Prior Authorization Request Form

DMAS/KePRO

Additional Information

14. Severity of Illness:
15. Intensity of Services:
16. Additional Comments:

Outpatient Prior Authorization Request Form

DMAS/KePRO

INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This FAX submission form is required for outpatient Prior Authorization Review, Concurrent Review and Retrospective Review. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on **KePRO** forms can be entered. Do **not** send attachments or non-**KePRO** forms.

If **KePRO** determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (http://dmas.kepro.org) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous preauthorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one preauthorization number. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
2. **Date of Request:** The date you are submitting the prior authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Retrospective review policy and procedure for each service detailed information regarding the submission of a Retrospective Review request. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Enrollee Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.
5. **Enrollee Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
6. **Enrollee First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.
7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).

Outpatient Prior Authorization Request Form

DMAS/KePRO

8. **Sex:** Please place a √ or **X** to indicate the sex of the patient.
9. **Requesting/Service Provider Name and Medicaid ID Number/NPI:** Enter the requesting/service provider name and Medicaid ID number or national provider identifier.
10. **Treatment Setting:** Place a √ or **X** to indicate the place of service: always mark "Outpatient."
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 descriptions and ICD-9 codes, as required.
12. **Referring Provider Name and Medicaid ID Number/NPI:** Enter the referring provider name and Medicaid ID number or national provider identifier for the provider requesting the service.
13. **PA Service Type:** Place a √ or **X** to indicate the category of service you are requesting. Orthotics: If enrollee is under 21 check "Orthotics (EPSDT)".
14. Severity of Illness (Clinical indicators of illness including abnormal findings)*:
    - **One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.**
    - **Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions/% as appropriate]).**
    - **Service Type specific instructions:**

Outpatient psych	**List all symptoms and behaviors supporting the need for outpatient psychiatric treatment. Clinical documentation should address safety risks (immediate or potential), level of functioning, adequacy of support system and social factors. For continued treatment, include clinical findings within the last five visits and progress towards treatment goals. Clinical updates should describe treatment compliance and any related changes to the individual's psychosocial and medical status.**
DME	**Provide all of the information listed in Section II of the CMN.**
Home Health - Rehab	**Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.**
Home Health – Skilled Nursing	**Describe specific orders for nursing.**
Rehab	**Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.**

15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:**
    - This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.

- This field must include the treatment plan for the patient. List the services, procedures, or treatments that will be provided to the patient.
- **Service Type specific instructions:**

Outpatient psych	**Identify the treatment modality (i.e. individual, family, or group), number and frequency of sessions and anticipated duration of treatment.**
DME	**Provide all of the information listed for each line item in Section III and IV of the CMN. Include all items and not only those that require preauthorization. (If there is no begin service date, list the physician's signature date that is on the backside of CMN.)**
Home Health - Rehab	**Describe long term and short term goals with achievement dates.**
Home Health – Skilled Nursing	**Specific description of goals and achievement dates; Specific description of procedures, especially if requesting comprehensive visits; If requesting ongoing comprehensive visits, specify why goals have not been accomplished.**
Rehab	**Identify if the plan of care is a 60-day plan of care (acute) or an annual plan of care (non-acute); Describe the long term and short term goals with achievement dates; Documentation of meeting program goals.**

16. **Additional Comments** This area must be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the regulations, DMAS manual, and InterQual criteria (see PA chapter in the DMAS manual).

Outpatient psych	**Confirm: psychosocial assessment completed; substance abuse and/or medication evaluations completed (if needed); and plan of care designed, signed, and dated by a Licensed Mental Health Provider (LMHP). Indicate where the service is being provided (Mental Health Clinic, provider's office, home, or nursing home).**

17. **HCPCS/CPT/Revenue Code:** Provide the HCPCS/CPT/Revenue procedure code.
18. **Code Description:** Provide the HCPCS/CPT/Revenue procedure code description. For NEOP, provide the type of scan and location.
19. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Supplies Listing/Appendix B found in the DMAS DME provider manual information.
20. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of InterQual/DMAS criteria will be extremely helpful. DME providers: Only identify the number of units necessary in excess of the established allowable for the time span requested. For example, if 2 cases of diapers are allowed per month and 3 cases are used per month, the overage is 1 case per month. If a timeframe of 6 months is requested by the From and Thru date, then the total Units Requested for the time

frame is 6 cases. Place numbers only in the Units Requested block. Units requested as 2/2 months or 100/box/month or 7 days cannot be keyed and will be rejected.

21. **Actual Cost per Unit or Usual and Customary (DME providers only)**: Enter information in this column for codes identified in Appendix B as individual consideration (IC) or usual and customary. For IC, enter actual cost per unit less any incentives/discounts or reductions received from the manufacturer. For items identified in Appendix B as usual and customary, enter the provider's usual and customary charge to the generic public. The provider must retain documentation supporting this dollar amount.
22. **Frequency**: Enter the frequency of the visits/service from the physician's order, plan of care or CMN. Not necessary for DME if included under Intensity of Service.
23. **Total Dollars Requested (DME providers only)**: Enter the dollar amount requested for items listed as usual and customary or IC in the appendix B of the DMAS DME Provider Manual. In the Appendix B, each code is listed with a set fee, as usual and customary or IC. The Total Dollars Requested is the total for all units requested in that line. For items listed as usual and customary enter your usual and customary charge to the general public. For items listed as IC enter the dollar amount requested. The provider must retain documentation supporting verification of cost (a manufacturer's invoice, brochure with cost information from the manufacturer, cost estimate on letterhead from the manufacturer, etc.) This cost is per unit of the item being requested, e.g. 1ea, 1 pair, or 1 box of 100.
24. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
25. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
26. **Contact Phone Number**: Enter the phone number with area code of the contact name.
27. **Contact Fax Number**: Enter the fax number with the area code to respond if there is a denial/reject.

****Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.***

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Inpatient Prior Authorization Request Form

DMAS/KePRO

Submit fax request for prior authorization to: 1-877–OKBYFAX (877-652-9329).

Requests may be submitted up to 30 days prior to scheduled procedures/services, provided the Enrollee is eligible.

Recert: Enter previous PA#. Change or Cancel: enter PA# to be changed or canceled.

2. ❑ Initial ❑ Recertification ❑ Change ❑ Cancel PA #_____

2. Date of request: (mm/dd/yyyy) ____/____/_____	**3. Review Type: (Please check one if applicable)** ☐ Retrospective Prepayment Review (Date notified of eligibility ____/____/_____) ☐ Retroactive MCO disenrollment			
4. Enrollee Medicaid ID Number (12 Digit number):	**5. Enrollee Last Name:**	**6. Enrollee First Name:**		
7. Date of Birth: (mm/dd/yyyy) ____/____/_____	**8. Sex:** ☐ **Male** ☐ **Female**	**9. Submitting Provider Name and Medicaid ID Number/NPI:**		
10. Facility Name and Medicaid ID Number/NPI:	**11. Treatment Setting:** ☐ **Inpatient** ☐ **CORF**	**12. Surgical Admission:** ☐ **Yes** ☐ **No**	**13. Admission Date: (mm/dd/yyyy) ____/____/_____**	**14. Admission Status:** ☐ **Urgent** ☐ **Elective**

15. Primary Diagnosis Code/Description: (enter up to 5)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

16. Number of Days Requested:	**17. Attending Physician Medicaid ID Number/NPI:**	**18. PA Service Type:** ☐ **0093 EPSDT Inpatient (Free standing) Psych** ☐ **0200 Intensive Rehabilitation** ☐ **0201 CORF** ☐ **0400 Inpatient Admission** ☐ **0401 Inpatient Psychiatric**
19. Procedure Code/Description:	**20. Procedure Scheduled Date: (mm/dd/yyyy) ____/____/_____**	

21. Severity of Illness (Clinical indicators of illness including abnormal findings):

22. Intensity of Services (Proposed/Actual monitoring and therapeutic services):

23. Additional Comments (See Instructions):

24. Contact Name: _____

25. Contact Telephone Number: _____

Inpatient Prior Authorization Request Form

DMAS/KePRO

26. Contact Fax Number: _____

Additional Information

21. Severity of Illness:
22. Intensity of Services:
23. Additional Comments (See Instructions):

Inpatient Prior Authorization Request Form

DMAS/KePRO

INSTRUCTIONS FOR ELECTRONIC FAX FORM

This FAX submission form is required for inpatient Prior Authorization Review, Admission, Concurrent Review and Retrospective Review. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on **KePRO** forms can be entered. Do **not** send attachments or non-**KePRO** forms.

If KePRO determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (http://dmas.kepro.org) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous preauthorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the notes fields. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one preauthorization number. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
2. **Date of Request:** The date you are submitted the prior authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Retrospective review policy and procedure for each service detailed information regarding the submission of a Retrospective Review request. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Enrollee Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.
5. **Enrollee Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
6. **Enrollee First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.
7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Sex:** Please place a √ or **X** to indicate the sex of the patient.

Inpatient Prior Authorization Request Form

DMAS/KePRO

9. **Submitting Provider Name and Medicaid ID Number/NPI:** Enter the requesting physician's name and Medicaid ID number or national provider identifier.
10. **Facility Name and Medicaid ID Number/NPI:** Enter the name and Medicaid Identification number or national provider identifier of the hospital where the physician is requesting that the patient be admitted.
11. **Treatment Setting:** Place a √ or **X** to indicate the place of service.
12. **Surgical Admission:** Indicate if this admission is surgical by placing a √ or **X** for yes or no in the appropriate box.
13. **Admission Date:** Indicate the planned admission date using the mm/dd/yyyy format.
14. **Admission Status:** Place a √ or **X** for Urgent/Elective admission. This refers to the clinical status of the patient that is being admitted.
15. **Primary Diagnosis Code/Description:** Provide the **primary diagnosis code and description** indicating the reason for admission. You can enter up to 5 admission descriptions and ICD-9 codes.
16. **Number of days requested:** Based on your judgment provide the number of days requested for this admission diagnosis. Knowledge of InterQual/DMAS criteria will be extremely helpful.
17. **Attending Physician Medicaid ID Number/NPI:** Provide the Attending Physician's Medicaid ID number or national provider identifier.
18. **PA Service Type:** Place a √ or **X** to indicate if this is a EPSDT Inpatient Psych, Intensive Rehabilitation, CORF, Inpatient Admission, or Inpatient Psychiatric admission.

Med\Surg	Claim must reflect a med\surg primary diagnosis code for this authorization to be valid and reimbursement to be made.
Psychiatric	Claim must reflect a primary diagnosis code within the ICD 9 cm range of 290 thru 319 for this authorization to be valid and reimbursement to be made.

19. **Procedure Code/Description:** Provide the ICD-9 procedure code and description to indicate the reason for the patient's admission. Be sure that the procedure code is **an ICD-9 code.**
20. **Procedure Scheduled Date:** If the procedure is scheduled on a different day from the planned admission date, indicate the date of the procedure (mm/dd/yyyy).
21. Severity of Illness (Clinical indicators of illness including abnormal findings)*: **One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information. Provide the clinical information of chief complaint, history of present illness, pertinent past medical history and previous treatment to substantiate the need for hospitalization and level of service for the requested admission/procedure. This field must include pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities. Include supportive diagnostic outpatient procedures and abnormal finding on physical examination. This information also assists the reviewers in further assessing the patient's condition. (Always include dates, types & results [with dimensions/% as appropriate]). Include TDO (Temporary Detention Order) date if applicable.**

Inpatient Prior Authorization Request Form

DMAS/KePRO

22. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:** This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information. This field must include the treatment plan for the patient while in the facility. List the services, procedures, or treatments that will be provided to the patient while in the facility.
23. **Additional Comments:** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the length of stay. For example, if a patient has been treated several times as an outpatient and failed therapy or has not followed through on treatment, then information of this sort should be placed here. For psychiatric cases, list the DSM-IV if available. For recipients admitted to freestanding facilities, CSB information is required. CSB information includes the screeners name, the date of the screening, the locality and the screeners title.
24. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
25. **Contact Phone Number:** Enter the phone number with area code of the contact name.
26. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

    Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.

    The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.